SPECIAL BULLETIN
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2000 CPT AND HCPCS UPDATES

Missouri Medicaid converted to the 2000 version of the *Physicians' Current Procedural Terminology (CPT)* effective January 1, 2000. GTE Data Services will begin accepting the 2000 procedure codes on May 1, 2000. All claims received by GTE Data Services on or after June 1, 2000, regardless of the dates of service, should contain only those Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) procedure codes found in the 2000 CPT book or the 2000 Level II procedure codes.

Changes that occurred as a result of the 2000 CPT updating were code deletions, terminology changes, and the addition of new codes. Missouri Medicaid additions, deletions, and replacement codes are listed in this bulletin (See Attachment A). Due to the number of procedure codes involved, we are unable to include the procedure code descriptions and terminology changes. This information can be found in the 2000 CPT book. Providers should obtain and refer to this publication to assure proper coding.

A copy of the *Physicians' Current Procedural Terminology (CPT)* may be purchased by writing to the following address:

Order Department
American Medical Association
P.O. Box 7046
Dover, DE 19903-7046
Telephone Number: (800)621-8335
Fax Orders: (312)464-5600

ADD-ON PROCEDURE CODES

Procedure codes designated as "add-on" codes with a "+" symbol in the 2000 CPT book are commonly carried out in addition to the primary procedure performed. Add-on codes can be readily identified by specific descriptor terminology which includes phrases such as "each additional"or "list separately in addition to primary procedure". The "add-on" code concept in CPT applies only to add-on procedures/services performed by the **same** practitioner. These codes describe additional intra-service work associated with the primary procedure. Add-on codes are always performed in addition to the primary service/procedure, and must **never** be reported as a stand-alone code. In addition to payment for the primary service/procedure, the add-on codes will also be paid at 100% of the Medicaid maximum allowable. See Attachment A for the new 2000 add-on codes. They are identified with the "+" symbol.

Please Note: Anesthesia should not be billed for an add-on procedure code. The anesthesia is billed using the major procedure code and the total number of minutes for the entire surgery.

Attachment A reflects add-on codes which are non-covered for type of service G, S, and W.

DURABLE MEDICAL EQUIPMENT (DME) 2000 HCPCS UPDATE

As a result of the 2000 HCPCS updates, the following procedure codes have been added as covered, deleted or the description of an existing procedure code has been changed effective for date of service January 1, 2000.

Two procedure codes have been deleted and replaced with alternative HCPCS codes. These changes became effective for all claims submitted on or after May 1, 2000, regardless of the date of service.

New Codes added for HCY Recipients Only

PROCEDURE CODE	DESCRIPTION	TOS	REIMBURSEMENT GUIDELINES	MEDICAID MAXIMUM ALLOWED AMOUNT
E0602	Breast pump, all types	T	M.N. Invoice of Cost	Manual Price (M.P.)

New Codes Added

PROCEDURE CODE	DESCRIPTION	TOS	REIMBURSEMENT GUIDELINES	MEDICAID MAXIMUM ALLOWED AMOUNT
A4369	Ostomy skin barrier, liquid (spray, brush, etc), per oz	A	Invoice of Cost	M.P.
A4370	Ostomy skin barrier, paste, per oz	A	Invoice of Cost	M.P.
A4371	Ostomy skin barrier, powder, per oz	A	Invoice of Cost	M.P.
A4372	Ostomy skin barrier, solid 4x4 or equivalent, standard wear, with built -in convexity, each	A	Invoice of Cost	M.P.
A4373	Ostomy skin barrier, with flange (solid, flexible or accordion), standard wear, with built-in convexity, any size, each	A	Invoice of Cost	M.P.

PROCEDURE CODE	DESCRIPTION	TOS	REIMBURSEMENT GUIDELINES	MEDICAID MAXIMUM ALLOWED AMOUNT
A4374	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, any size, each	A	Invoice of Cost	M.P.
A4375	Ostomy pouch, drainable, with faceplate attached, plastic, each	A	Invoice of Cost	M.P.
A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each	A	Invoice of Cost	M.P.
A4377	Ostomy pouch, drainable, for use on faceplate, plastic, each	A	Invoice of Cost	M.P.
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each	A	Invoice of Cost	M.P.
A4379	Ostomy pouch, urinary, with faceplate attached, plastic, each	A	Invoice of Cost	M.P.
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each	A	Invoice of Cost	M.P.
A4381	Ostomy pouch, urinary, for use on faceplate, plastic, each	A	Invoice of Cost	M.P.
A4382	Ostomy pouch, for use on faceplate, heavy plastic, each	A	Invoice of Cost	M.P.
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each	A	Invoice of Cost	M.P.
A4384	Ostomy faceplate equivalent, silicone ring, each	A	Invoice of Cost	M.P.
A4385	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each	A	Invoice of Cost	M.P.

PROCEDURE CODE	DESCRIPTION	TOS	REIMBURSEMENT GUIDELINES	MEDICAID MAXIMUM ALLOWED AMOUNT
A4386	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear without built-in convexity, any size, each	A	Invoice of Cost	M.P.
A4387	Ostomy pouch closed, with standard wear barrier attached, with built-in convexity (1 piece), each	A	Invoice of Cost	M.P.
A4388	Ostomy pouch, drainable, with extended wear barrier attached, without built-in convexity (1 piece)	A	Invoice of Cost	M.P.
A4389	Ostomy pouch, drainable, with standard wear barrier attached, with built-in convexity (1 piece), each	A	Invoice of Cost	M.P.
A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each	A	Invoice of Cost	M.P.
A4391	Ostomy pouch, urinary with extended wear barrier attached, without built-in convexity (1 piece), each	A	Invoice of Cost	M.P.
A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each	A	Invoice of Cost	M.P.
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each	A	Invoice of Cost	M.P.

PROCEDURE CODE	DESCRIPTION	TOS	REIMBURSEMENT GUIDELINES	MEDICAID MAXIMUM ALLOWED AMOUNT
A5508	For diabetic only, deluxe feature of off-the-shelf depth-inlay shoe or custom molded shoe, per shoe	A	Prior Authorization	M.P.

Code Deleted

Procedure Code	Description
A4363	Skin barrier, liquid (spray, brush, etc.) Powder or paste, per ounce

Procedure Codes Deleted with Replacement Codes

PROCEDURE CODE DELETED	DESCRIPTION	REPLACEMENT CODE	TOS	REIMBURSEMENT GUIDELINES	MEDICAID MAXIMUM ALLOWED AMOUNT
E0452	Intermittent Assist Device with Continuous Positive Airway Pressure Device (BiPap S)	K0532	T	Prior Authorization and Sleep Study	$268.00
E0453	Therapeutic Ventilator, Suitable for use 12 hours or less per day, (Bi-Pap ST)	K0533	T	Prior Authorization	$597.00

As a result of the 2000 HCPCS updates, the following procedure codes have been added as covered effective for dates of service on or after January 1, 2000.

Some procedure codes have been deleted and replaced with new HCPCS procedure codes effective for dates of service on or after June 1, 2000.

New Codes added for HCY Recipients Only

PROCEDURE CODE	DESCRIPTION	REIMBURSEMENT GUIDELINES	MEDICAID MAXIMUM ALLOWED AMOUNT
D0350 *This code replaces D0471YG*	Oral/facial images (includes intra and extraoral images) *This includes both traditional photographs and images obtained by intraoral cameras. These images should be a part of the patient's clinical record. Excludes conventional radiographs.*		$12.50
D2337	Resin-based composite crown, anterior - permanent		$65.00
D2542	Onlay - metallic - two surfaces	Prior Authorization	MP
D2780	Crown - 3/4 cast high noble metal	Prior Authorization	MP
D2781	Crown - 3/4 cast predominately base metal	Prior Authorization	MP
D2782	Crown - 3/4 cast noble metal	Prior Authorization	MP
D2783 *This code replaces D2810*	Crown 3/4 porcelain/ceramic *This code does not include facial veneers.*	Prior Authorization	MP
D2953	Each addition cast post - same tooth	To be used with D2954	$69.00
D2957	Each additional prefabricated post - same tooth	To be used with D2954	$60.00
PROCEDURE CODE	**DESCRIPTION**	**REIMBURSEMENT GUIDELINES**	**MEDICAID MAXIMUM ALLOWED AMOUNT**

D5867	Replacement of replaceable part of semi-precision or precision attachment (male of female component)	Certificate of Medical Necessity	MP
D6245	Pontic - porcelain/ceramic	Prior Authorization	MP
D6519	Inlay/onlay - porcelain	Prior Authorization	MP
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Prior Authorization	MP
D6740	Crown - porcelain/ceramic	Prior Authorization	MP
D6781	Crown - 3/4 cast predominately based metal	Prior Authorization	MP
D6782	Crown - 3/4 cast noble metal	Prior Authorization	MP
D6783	Crown - 3/4 porcelain/ceramic	Prior Authorization	MP
D6976	Each additional cast post - same tooth	Prior Authorization To be used with D6970 & D6971	$69.00
D6977	Each additional prefabricated post - same tooth	Prior Authorization To be used with D6972	$60.00
D8691	Repair of orthodontic	Certificate of Medical Necessity (Explain what repairs were made, the time spent on the repair and what parts were used in the repair.)	MP
D8692	Replacement of lost or broken retainer		$120.00

New Codes Added Adults and HCY

PROCEDURE CODE	DESCRIPTION	REIMBURSEMENT GUIDELINES	MEDICAID MAXIMUM ALLOWED AMOUNT

D0277	Vertical bitewings - 7 to 8 films	Can not bill these on same day as regular bitewings	$33.00
D2388	Resin-based composite - four or more surfaces, posterior permanent		$108.00
D2799	Provisional crown - *Crown utilized as an interim restoration of at least six months duration during restorative treatment to all ow adequate time for healing or completion of other procedures. This includes, but is not limited to, changing vertical dimension, completing periodontal therapy or cracked tooth syndrome. This is not to be used as a temporary crown for a routine restoration.*	Can not bill this on the same day as crowns	$49.00
D3221	Gross pupal debridement, primary and permanent teeth - *Gross pulpal debridement for the relief of acute pain prior to conventional root canal therapy.*		MP
D3331	Treatment of root canal obstruction; non-surgical access		MP
D3332	Incomplete endodontic therapy; inoperable or fractured tooth		MP
D3333	Internal repair of perforation defects		MP
D4245	Apically positional flap	Operative report	MP
D4268	Surgical revision procedure, per tooth	Operative report	MP
PROCEDURE CODE	**DESCRIPTION**	**REIMBURSEMENT GUIDELINES**	**MEDICAID MAXIMUM ALLOWED AMOUNT**
D7471	Removal or exostosis, per site	Operative report	MP
D7871	Non-arthroscopic lysis and lavage	Operative report	MP

D9241 *This code replaces D9240*	Intravenous sedation/analgesia - first 30 minutes		$55.00
D9242 *This code replaces D9240*	Intravenous sedation/analgesia - each additional 15 minutes		$25.00
D9248	Non-intravenous conscious sedation		$20.00
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Not to be used for bases, liners, or adhesives used under restoration.	$11.00

Deleted 2000 HCPCS Codes

PROCEDURE CODE	DESCRIPTION	REIMBURSEMENT GUIDELINES
D0471YG	Diagnostic photographs (used in orthodontic program)	Replaced by D0350
D2210	Silicate cement	No replacement code
D2810	Crown - 3/4 cast metallic	Replaced by D2783
D3960	Bleaching of discolored tooth	Not a Medicaid covered service
D4250	Mucogingival surgery - per quadrant	No replacement code
D7470	Removal of exostosis	No replacement code
D7942	Osteotomy - ramus, open	No replacement code
D9240	Intravenous sedation	Replaced by D9241 and D9242

VAGUS NERVE STIMULATION

Vagus nerve stimulation is covered for patients with medically refractory partial onset epileptic seizures for whom surgery is not recommended or for whom surgery has failed.

The procedure is performed in the hospital and usually requires an overnight stay. Surgeons should code the implant procedure as 64573 (electrode placement) and 64590 (neurostimulator placement) with type of service 2.

In addition, a physician (usually a neurologist) typically tests the device and leads and sets the initial programming parameters, both in the operating room and in the office setting during the days/weeks following the implant. The physician should bill the following CPT codes:

Procedure Code	Type of Service
95970	1
95974	1
95975	1

These analysis and programming procedure codes may also be billed periodically to test and reprogram the device.

The device is included in the hospital per diem if the surgery is performed in an inpatient hospital setting. If the surgery is performed in an outpatient hospital setting, the device is billable under the outpatient supply code.

VFC ADMINISTRATION

Under a provision of the Omnibus Budget Reconciliation Act (OBRA) of 1993, vaccine is available free to providers who enroll with the Vaccines for Children (VFC) Program for children ages 0 through 18 years who are Medicaid-enrolled, uninsured, Native American/Alaskan Native, or under insured. Medicaid enrolled providers and plan providers *must* enroll in the VFC Program. The VFC Program is administered by the Missouri Department of Health. Providers can obtain enrollment information by contacting the Missouri Department of Health at the following address or telephone number:

Missouri Department of Health
Bureau of Immunizations
P.O. Box 570
Jefferson City, MO 65102
(800)219-3224
FAX: (573)526-5220

VFC ADMINISTRATION CODES

Missouri Medicaid will pay an administration fee of $5.00 per component to enrolled VFC providers to administer the free vaccine to a Medicaid recipient, except to those providers enrolled as Rural Health Clinics (RHC) or Federally-Qualified Health Clinics (FQHC). RHCs and FQHCs may bill an encounter code or appropriate level Evaluation and Management code for VFC immunizations, but may not bill an additional administration fee for any vaccine.

Procedure codes are billable using type of service 1 or 3. Note: type of service 3 (Nurse Midwife) must follow age limitations as defined in their scope of practice.

PROCEDURE CODE	DESCRIPTION	MAXIMUM ALLOWABLE
90633YG	Administration of immunization; Hepatitis A vaccine, pediatric/adolescent dosage - 2 dose schedule, for intramuscular use (Age 2-18 years)	$5.00
90645YG	Administration of immunization; Hemophilus influenza B vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use (Age 6 weeks-5 years)	$5.00
90646YG	Administration of immunization; Hemophilus influenza B vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use (Age 6 weeks-5 years)	$5.00
90647YG	Administration of immunization; Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use (Age 6 weeks-5 years)	$5.00
90648YG	Administration of immunization; Hemophilus influenza B vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use (Age 6 weeks-5 years)	$5.00
90657YG	Administration of immunization; influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use (Age 6 months-2 years, who are high-risk)	$5.00
90658YG	Administration of immunization; influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use (Age 3-18 years, who are high-risk)	$5.00

PROCEDURE CODE	DESCRIPTION	MAXIMUM ALLOWABLE
90700YG	Administration of immunization; Diphtheria, Tetanus toxoids, and Acellular Pertussis vaccine (DTaP), for intramuscular use (Age 6 weeks-7 years)	$15.00
90702YG	Administration of immunization; Diphtheria and Tetanus toxoids (DT) adsorbed for pediatric use, for intramuscular use (Age 0-7 years)	$10.00

90707YG	Administration of immunization; Measles, Mumps and Rubella virus vaccine (MMR), live, for subcutaneous or jet injection use (Age 12 months-18 years)	$15.00
90712YG	Administration of immunization; Poliovirus vaccine, (any type(s)) (OPV), live, for oral use (Age 6 weeks-18 years)	$5.00
90713YG	Administration of immunization; Poliovirus vaccine, inactivated, (IPV), for subcutaneous use (Age 6 weeks-18 years)	$5.00
90716YG	Administration of immunization; Varicella virus vaccine, live, for subcutaneous use (Age 12 months-18 years)	$5.00
90718YG	Administration of immunization; Tetanus and Diphtheria toxoids (Td) adsorbed for adult use, for intramuscular or jet injection (Age 11-18 years)	$10.00
90721YG	Administration of immunization; Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use (Age 15 months-18 months or for the fourth dose only)	$20.00
90732YG	Administration of immunization; Pneumococcal Polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use (Age 2-18 years who have a chronic illness)	$5.00
90744YG	Administration of immunization; Hepatitis B vaccine, pediatric/adolescent dosage, for intramuscular use (Age 0-18 years)	$5.00

PROCEDURE CODE	DESCRIPTION	MAXIMUM ALLOWABLE
90746YG	Administration of immunization; Hepatitis B vaccine, adult dosage, for intramuscular use (Age 11-18 years)	$5.00
90748YG	Administration of immunization; Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use; Comvax (Age 2 months-18 months)	$10.00

CORRECTION

The diagnosis code listing in the Physician Bulletin, Vol. 22, No. 1, dated November 1, 1999, page 4, was incomplete. The following is the complete list of appropriate diagnoses for procedure codes 9923199, 9923299 and 9923399. These codes are limited to services provided to newborns/infants for specific diagnosis codes, which are 038.0-038.9, 773.0-773.5, 765.00-765.07, 765.10-765.17, 769, 774.0-774.7 and 775.6. The "99" modifier increases the fee for subsequent hospital services provided to newborns/infants when any of the above diagnosis codes are used.

REMINDER

Nurse Midwives must bill the Norplant device and Depo-Provera on the Pharmacy Claim Form using the National Drug Code (NDC).

PHYSICIAN PSYCHIATRIC SERVICES

Changes have been made to the diagnosis list for psychiatric services. Claims for psychiatric procedures require one of the following diagnosis codes as the primary diagnosis in order for the claim to be considered for payment. Diagnosis codes are 290 - 316 V11-V118, V154-V1542, V17-V170, V40-V401, V61-V619, V624, V628-V6289, V673, V710-V7102, and V79-V791. Psychiatric services must be consistent with the diagnosis.

PSYCHOLOGY/COUNSELING/SOCIAL WORK SERVICES

Changes have been made to the diagnosis list for psychology/counseling/social work services. Claims for psychology procedures require one of the following diagnosis codes as the primary

diagnosis in order for the claim to be considered for payment. Diagnosis codes are 290 - 316, V11-V118, V154-V1542, V17-V170, V40-V401, V61-V619, V624, V628-V6289, V673, V710-V7102, and V79-V791. Psychology/counseling/social work services must be consistent with the diagnosis.

NAME CHANGE

Documentation must accompany claims for a recipient whose name changes after a form is completed, (i.e., sterilization, second opinion). For example, a letter of explanation should be submitted to document a name change due to marriage or divorce.